

		FOR OHF USE					

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2003
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2003)

IMPORTANT NOTICE
 THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION
 THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY
 PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE
 OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE
 ANY INFORMATION ON OR BEFORE THE DUE DATE WILL
 RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM
 HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: <u>0045146</u>		II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER	
Facility Name: <u>Warren Barr Pavilion</u>		I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>01/01/03</u> to <u>12/31/03</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.	
Address: <u>66 West Oak Street</u> <u>Chicago</u> <u>60610</u> Number City Zip Code		Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.	
County: <u>Cook</u>		Officer or Administrator of Provider (Signed) _____ (Date) _____ (Type or Print Name) _____ (Title) _____	
Telephone Number: <u>(312) 337-5400</u> Fax # <u>(312) 337-5041</u>		Paid Preparer (Signed) _____ (Date) _____ (Print Name and Title) <u>Steven N. Lavenda, C.P.A.</u> (Firm Name & Address) <u>Frost, Ruttenberg & Rothblatt, P.C.</u> <u>111 Pfingsten Road, Suite 300 Deerfield, IL 60015</u> (Telephone) <u>(847) 236-1111</u> Fax # <u>(847) 236-1155</u>	
IDPA ID Number: <u>721524884001</u>		MAIL TO: OFFICE OF HEALTH FINANCE ILLINOIS DEPARTMENT OF PUBLIC AID 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630	
Date of Initial License for Current Owners: <u>11/01/00</u>			
Type of Ownership:			
<input type="checkbox"/> VOLUNTARY, NON-PROFIT <input type="checkbox"/> Charitable Corp. <input type="checkbox"/> Trust IRS Exemption Code _____		<input checked="" type="checkbox"/> PROPRIETARY <input type="checkbox"/> Individual <input type="checkbox"/> Partnership <input type="checkbox"/> Corporation <input type="checkbox"/> "Sub-S" Corp. <input checked="" type="checkbox"/> Limited Liability Co. <input type="checkbox"/> Trust <input type="checkbox"/> Other _____	
<input type="checkbox"/> GOVERNMENTAL <input type="checkbox"/> State <input type="checkbox"/> County <input type="checkbox"/> Other _____			
In the event there are further questions about this report, please contact: Name: <u>Steve Lavenda</u> Telephone Number: <u>(847) 236 - 1111</u>			

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Warren Barr Pavilion# 0045146 Report Period Beginning: 01/01/03 Ending: 12/31/03

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days,
(must agree with license). Date of change in licensed bedsN/A

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>271</u>	Skilled (SNF)	<u>271</u>	<u>98,915</u>	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>271</u>	TOTALS	<u>271</u>	<u>98,915</u>	7

B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Public Aid Recipient	Private Pay	Other	Total	
8	SNF	<u>15,005</u>	<u>22,836</u>	<u>21,176</u>	<u>59,017</u>	8
9	SNF/PED					9
10	ICF	<u>4,867</u>	<u>5,606</u>		<u>10,473</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>19,872</u>	<u>28,442</u>	<u>21,176</u>	<u>69,490</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed
bed days on line 7, column 4.) 70.25%

D. How many bed-hold days during this year were paid by Public Aid?

None (Do not include bed-hold days in Section B.)E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)N/A

F. Does the facility maintain a daily midnight census?

YesG. Do pages 3 & 4 include expenses for services or
investments not directly related to patient care?YES ☐ NO ☒

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?

YES ☐ NO ☒

I. On what date did you start providing long term care at this location?

Date started 12/01/02

J. Was the facility purchased or leased after January 1, 1978?

YES ☒ Date 12/01/02 NO ☐

K. Was the facility certified for Medicare during the reporting year?

YES ☒ NO ☐ If YES, enter numberof beds certified 271 and days of care provided 15,078Medicare Intermediary AdminaStar Federal

IV. ACCOUNTING BASIS

ACCRUAL ☒ MODIFIED CASH* ☐ CASH* ☐Is your fiscal year identical to your tax year? YES ☒ NO ☐Tax Year: 12/31/03 Fiscal Year: 12/31/03

* All facilities other than governmental must report on the accrual basis.

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS

Page 3

Facility Name & ID Number Warren Barr Pavilion

0045146

Report Period Beginning: 01/01/03

Ending: 12/31/03

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	A. General Services											
1	Dietary	740,906	98,615	68,045	907,566		907,566	13,554	921,120			1
2	Food Purchase		636,023		636,023		636,023	(17,289)	618,734			2
3	Housekeeping	286,965	35,995	203,283	526,243		526,243		526,243			3
4	Laundry	65,934	68,515	134,588	269,037		269,037		269,037			4
5	Heat and Other Utilities			396,912	396,912		396,912	4,114	401,026			5
6	Maintenance	150,044	7,701	283,914	441,659		441,659	(34,083)	407,576			6
7	Other (specify):*											7
8	TOTAL General Services	1,243,849	846,849	1,086,742	3,177,440		3,177,440	(33,704)	3,143,736			8
	B. Health Care and Programs											
9	Medical Director			68,331	68,331		68,331		68,331			9
10	Nursing and Medical Records	4,414,765	42,359	487,140	4,944,264		4,944,264	66,336	5,010,600			10
10a	Therapy	196,215	1,571		197,786		197,786		197,786			10a
11	Activities	251,698	39,058	20,127	310,883		310,883		310,883			11
12	Social Services	199,603	1,119		200,722		200,722		200,722			12
13	Nurse Aide Training											13
14	Program Transportation											14
15	Other (specify):*							8,524	8,524			15
16	TOTAL Health Care and Programs	5,062,281	84,107	575,598	5,721,986		5,721,986	74,860	5,796,846			16
	C. General Administration											
17	Administrative	59,723		957,410	1,017,133		1,017,133	(291,508)	725,625			17
18	Directors Fees											18
19	Professional Services			92,415	92,415		92,415	(2,286)	90,129			19
20	Dues, Fees, Subscriptions & Promotions			78,456	78,456		78,456	(11,886)	66,570			20
21	Clerical & General Office Expenses	220,162	51,667	420,544	692,373		692,373	(291,840)	400,533			21
22	Employee Benefits & Payroll Taxes			1,344,162	1,344,162		1,344,162		1,344,162			22
23	Inservice Training & Education											23
24	Travel and Seminar			1,507	1,507		1,507		1,507			24
25	Other Admin. Staff Transportation			71,304	71,304		71,304	(18,691)	52,613			25
26	Insurance-Prop.Liab.Malpractice			302,536	302,536		302,536		302,536			26
27	Other (specify):*							71,293	71,293			27
28	TOTAL General Administration	279,885	51,667	3,268,334	3,599,886		3,599,886	(544,918)	3,054,968			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	6,586,015	982,623	4,930,674	12,499,312		12,499,312	(503,762)	11,995,550			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

SEE ACCOUNTANTS' COMPILATION REPORT

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

STATE OF ILLINOIS

Page 4

Facility Name & ID Number Warren Barr Pavilion

#0045146

Report Period Beginning:

01/01/03

Ending:

12/31/03

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			59,752	59,752		59,752	636,679	696,431			30
31	Amortization of Pre-Op. & Org.							143,518	143,518			31
32	Interest			10,708	10,708		10,708	452,253	462,961			32
33	Real Estate Taxes			600,000	600,000		600,000		600,000			33
34	Rent-Facility & Grounds			585,000	585,000		585,000	(541,265)	43,735			34
35	Rent-Equipment & Vehicles			30,635	30,635		30,635	2,286	32,921			35
36	Other (specify):*											36
37	TOTAL Ownership			1,286,095	1,286,095		1,286,095	693,471	1,979,566			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		955,713	1,017,846	1,973,559		1,973,559	77,739	2,051,298			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			148,373	148,373		148,373		148,373			42
43	Other (specify):*	72,856	2,033	107,795	182,684		182,684	(169,057)	13,627			43
44	TOTAL Special Cost Centers	72,856	957,746	1,274,014	2,304,616		2,304,616	(91,318)	2,213,298			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	6,658,871	1,940,369	7,490,783	16,090,023		16,090,023	98,391	16,188,414			45

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS

Page 5

Facility Name & ID Number Warren Barr Pavilion

0045146

Report Period Beginning: 01/01/03

Ending: 12/31/03

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.

In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer- ence	3 OHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(14,686)	02		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	5,150	30		9
10	Interest and Other Investment Income	(396)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(2,603)	02		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(6,983)	21		18
19	Entertainment	(18,691)	25		19
20	Contributions	(3,933)	21		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(280,433)	21		24
25	Fund Raising, Advertising and Promotional	(10,002)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising	(1,884)	20		28
29	Other-Attach Schedule	(234,626)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (569,087)		\$	30

OHF USE ONLY						
48		49	50	51	52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
	Amortization of Organization &			
33	Pre-Operating Expense			33
	Adjustments for Related Organization			
34	Costs (Schedule VII)	667,478		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 667,478		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ 98,391		37

*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			\$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$		47

SEE ACCOUNTANTS' COMPILATION REPORT

Warren Barr Payroll

0045146

Report Period Beginning: 01/01/03

Ending: 12/31/03

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference
1	Misc. Income	\$ (491)	21
2			2
3	Building Company Legal Fees	(76)	19
4	Building Company Bank Fees	(19,149)	21
5	Building Company Licenses	(339)	20
6	Building Company Miscellaneous	(80)	21
7	Capitalized Repairs & Maintenance	(43,640)	06
8	Marketing Salary	(12,896)	43
9	Marketing Consultant	(24,154)	43
10	Advertising-Marketing	(67,378)	43
11	Marketing Expenses-Other	(4,669)	43
12	Pre-Period Legal	(000)	19
13	Non-allowable Legal	(281)	19
14	Non-allowable Accounting	(1,154)	19
15			15
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99			99
100			100
101	Total	(234,626)	101

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Warren Barr Pavilion

0045146

Report Period Beginning:

01/01/03

Ending:

12/31/03

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary			13,554									13,554	1
2	Food Purchase	(17,289)											(17,289)	2
3	Housekeeping													3
4	Laundry													4
5	Heat and Other Utilities			4,114									4,114	5
6	Maintenance	(43,660)		9,577									(34,083)	6
7	Other (specify):*													7
8	TOTAL General Services	(60,949)		27,245									(33,704)	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records			66,336									66,336	10
10a	Therapy													10a
11	Activities													11
12	Social Services													12
13	Nurse Aide Training													13
14	Program Transportation													14
15	Other (specify):*			8,524									8,524	15
16	TOTAL Health Care and Programs			74,860									74,860	16
	C. General Administration													
17	Administrative			(291,508)									(291,508)	17
18	Directors Fees													18
19	Professional Services	(1,831)	(455)										(2,286)	19
20	Fees, Subscriptions & Promotions	(12,216)	330										(11,886)	20
21	Clerical & General Office Expenses	(311,097)	19,257										(291,840)	21
22	Employee Benefits & Payroll Taxes													22
23	Inservice Training & Education													23
24	Travel and Seminar													24
25	Other Admin. Staff Transportation	(18,691)											(18,691)	25
26	Insurance-Prop.Liab.Malpractice													26
27	Other (specify):*			71,293									71,293	27
28	TOTAL General Administration	(343,835)	19,132	(220,215)									(544,918)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(404,784)	19,132	(118,110)									(503,762)	29

Summary B

Facility Name & ID Number	Warren Barr Pavilion	#	0045146	Report Period Beginning:	01/01/03	Ending:	12/31/03
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SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS
													(to Sch V, col.7)
30	Depreciation	5,150	609,991	21,538									636,679
31	Amortization of Pre-Op. & Org.		143,518										143,518
32	Interest	(396)	447,253	5,396									452,253
33	Real Estate Taxes												
34	Rent-Facility & Grounds		(585,000)	43,735									(541,265)
35	Rent-Equipment & Vehicles			2,286									2,286
36	Other (specify):*												
37	TOTAL Ownership	4,754	615,762	72,955									693,471
	Ancillary Expense												
	E. Special Cost Centers												
38	Medically Necessary Transportation												
39	Ancillary Service Centers				77,739								77,739
40	Barber and Beauty Shops												
41	Coffee and Gift Shops												
42	Provider Participation Fee												
43	Other (specify):*	(169,057)											(169,057)
44	TOTAL Special Cost Centers	(169,057)			77,739								(91,318)
	GRAND TOTAL COST												
45	(sum of lines 29, 37 & 44)	(569,087)	634,894	(45,155)	77,739								98,391

Facility Name & ID Number Warren Barr Pavilion# 0045146

Report Period Beginning:

01/01/03

Ending:

12/31/03

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
See Attached		See Attached		See Attached		

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V	2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	34 Rental Income	\$ 585,000	Warren Barr Realty	100.00%	\$	\$(585,000)	1
2	V	19 Legal Fees		Warren Barr Realty		76	76	2
3	V	19 Accounting Fees		Warren Barr Realty		(531)	(531)	3
4	V	21 Bank Fees		Warren Barr Realty		19,169	19,169	4
5	V	20 Licenses		Warren Barr Realty		330	330	5
6	V	21 Miscellaneous		Warren Barr Realty		88	88	6
7	V	30 Depreciation		Warren Barr Realty		609,991	609,991	7
8	V	31 Amortization		Warren Barr Realty		143,518	143,518	8
9	V	32 Interest Expense		Warren Barr Realty		447,253	447,253	9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$ 585,000			\$ 1,219,894	\$ * 634,894	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Warren Barr Pavilion

0045146

Report Period Beginning: 01/01/03

Ending: 12/31/03

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	17 Management Fees	\$ 957,410	Boulevard Healthcare Management, LLC	100.00%	\$	\$ (957,410)	15
16	V	5 Utilities		Boulevard Healthcare Management, LLC	100.00%	4,114	4,114	16
17	V	10 Nursing & Rehabilitation		Boulevard Healthcare Management, LLC	100.00%	66,336	66,336	17
18	V	15 Payroll Taxes, Fringes, Staff Dev.		Boulevard Healthcare Management, LLC	100.00%	8,524	8,524	18
19	V	1 Dietary Expenses		Boulevard Healthcare Management, LLC	100.00%	13,554	13,554	19
20	V	17 Administrative & General		Boulevard Healthcare Management, LLC	100.00%	665,902	665,902	20
21	V	6 Maint. & Minor Equipment		Boulevard Healthcare Management, LLC	100.00%	9,577	9,577	21
22	V	27 Payroll Taxes, Fringes, Staff Dev.		Boulevard Healthcare Management, LLC	100.00%	71,293	71,293	22
23	V	30 Depreciation		Boulevard Healthcare Management, LLC	100.00%	21,538	21,538	23
24	V	34 Lease & Rent - Building		Boulevard Healthcare Management, LLC	100.00%	43,735	43,735	24
25	V	35 Lease & Rent - Equipment		Boulevard Healthcare Management, LLC	100.00%	2,286	2,286	25
26	V	32 Interest Expense		Boulevard Healthcare Management, LLC	100.00%	5,396	5,396	26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$ 957,410			\$ 912,255	\$ * (45,155)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Warren Barr Pavilion# 0045146Report Period Beginning: 01/01/03Ending: 12/31/03

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	10A REHAB CONSULTING	\$	ADVANCED THERAPY & REHAB, LLC	100.00%	\$	\$	15
16	V	39 ANCILLARY REHAB	1,017,845	ADVANCED THERAPY & REHAB, LLC	100.00%	1,095,584	77,739	16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$ 1,017,845			\$ 1,095,584	\$ * 77,739	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Warren Barr Pavilion# 0045146Report Period Beginning: 01/01/03Ending: 12/31/03

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V	2 Line	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
		Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
15	V		\$			\$	\$	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$			\$	\$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Warren Barr Pavilion# 0045146Report Period Beginning: 01/01/03Ending: 12/31/03

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V	2 Line	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
		Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
15	V		\$			\$	\$	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$			\$	\$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Warren Barr Pavilion# 0045146Report Period Beginning: 01/01/03Ending: 12/31/03

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V	2 Line	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
		Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
15	V		\$			\$	\$	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$			\$	\$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Warren Barr Pavilion# 0045146Report Period Beginning: 01/01/03Ending: 12/31/03

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V	2 Line	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
		Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
15	V		\$			\$	\$	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$			\$	\$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Warren Barr Pavilion# 0045146Report Period Beginning: 01/01/03Ending: 12/31/03

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V	2 Line	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
		Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
15	V		\$			\$	\$	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$			\$	\$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Warren Barr Pavilion# 0045146Report Period Beginning: 01/01/03Ending: 12/31/03

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V	2 Line	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
		Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
15	V		\$			\$	\$	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$			\$	\$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Warren Barr Pavilion# 0045146Report Period Beginning: 01/01/03Ending: 12/31/03

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V	2 Line	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
		Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
15	V		\$			\$	\$	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$			\$	\$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Warren Barr Pavilion # 0045146 Report Period Beginning: 01/01/03 Ending: 12/31/03

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Brian Cloch	Dir. Of Operations	Management	2.10%	See Attached	2.80	12.00%	Allocat Salary	\$ 23,974	17-07	1
2	Fred Benjamin	Owner	Administrative	0.70%	See Attached	10.09	19.00%	Allocat Salary	57,697	17-07	2
3	Jeff Elowe	Administrative	Administrative	2.10%	See Attached	4.48	12.00%	Allocat Salary	44,844	17-07	3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 126,515		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees).
FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME,
ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Warren Barr Pavilion# 0045146 Report Period Beginning:01/01/03Ending: 12/31/03

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☒

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

B. Show the allocation of costs below. If necessary, please attach worksheets.

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Warren Barr Pavilion# 0045146

Report Period Beginning:

01/01/03Ending: 12/31/03

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐

Name of Related Organization Boulevard Healthcare Management, LLC
 Street Address 8950 Gross Point Road, Suite 600
 City / State / Zip Code Skokie, IL 60077
 Phone Number (847) 663-1155
 Fax Number (847) 663-0917

B. Show the allocation of costs below. If necessary, please attach worksheets.

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6			
	1					\$	\$			1		
	2	5	Utilities	Patient Days/Direct	326,889	6	19,339	69,542	4,114	2		
	3	10	Nursing & Rehabilitation	Patient Days/Direct	326,889	6	312,818	69,542	66,336	3		
	4	15	Payroll Taxes,Fringes, Staff Dev.	Patient Days/Direct	326,889	6	40,068	69,542	8,524	4		
	5	1	Dietary Expenses	Patient Days/Direct	326,889	6	54,630	69,542	13,554	5		
	6	17	Administrative & General	Patient Days/Direct	326,889	6	2,957,288	2,303,745	69,542	665,902	6	
	7	6	Maint. & Minor Equipment	Patient Days/Direct	326,889	6	45,017	38,963	69,542	9,577	7	
	8	27	Payroll Taxes,Fringes, Staff Dev.	Patient Days/Direct	326,889	6	323,551	69,542	71,293	8		
	9	30	Depreciation	Patient Days/Direct	326,889	6	101,243	69,542	21,538	9		
	10	34	Lease & Rent - Building	Patient Days/Direct	326,889	6	205,579	69,542	43,735	10		
	11	35	Lease & Rent - Equipment	Patient Days/Direct	326,889	6	10,745	69,542	2,286	11		
	12	32	Interest Expense	Patient Days/Direct	326,889	6	25,363	69,542	5,396	12		
	13									13		
	14									14		
	15									15		
	16									16		
	17									17		
	18									18		
	19									19		
	20									20		
	21									21		
	22									22		
	23									23		
	24									24		
	25	TOTALS				\$	4,095,642	\$	2,709,156	\$	912,255	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Warren Barr Pavilion# 0045146

Report Period Beginning:

01/01/03Ending: 12/31/03

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐

Name of Related Organization ADVANCED THERAPY AND REHAB, LLC
 Street Address 8950 GROSS POINT RD. #E
 City / State / Zip Code SKOKIE, IL 60077
 Phone Number (847)663-1155
 Fax Number (847)663-0917

B. Show the allocation of costs below. If necessary, please attach worksheets.

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	<u>10A</u>	<u>REHAB CONSULTING</u>	<u>DIRECT ALLOCATION</u>						1
2	<u>39</u>	<u>ANCILLARY REHAB</u>	<u>DIRECT ALLOCATION</u>					1,095,584	2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$ 1,095,584	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Warren Barr Pavilion# 0045146

Report Period Beginning:

01/01/03Ending: 12/31/03

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

B. Show the allocation of costs below. If necessary, please attach worksheets.

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Warren Barr Pavilion# 0045146

Report Period Beginning:

01/01/03Ending: 12/31/03

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

B. Show the allocation of costs below. If necessary, please attach worksheets.

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Warren Barr Pavilion# 0045146

Report Period Beginning:

01/01/03Ending: 12/31/03

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

B. Show the allocation of costs below. If necessary, please attach worksheets.

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Warren Barr Pavilion# 0045146

Report Period Beginning:

01/01/03Ending: 12/31/03

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

B. Show the allocation of costs below. If necessary, please attach worksheets.

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Warren Barr Pavilion# 0045146

Report Period Beginning:

01/01/03Ending: 12/31/03

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

B. Show the allocation of costs below. If necessary, please attach worksheets.

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Warren Barr Pavilion# 0045146

Report Period Beginning:

01/01/03Ending: 12/31/03

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

B. Show the allocation of costs below. If necessary, please attach worksheets.

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Warren Barr Pavilion# 0045146

Report Period Beginning:

01/01/03Ending: 12/31/03

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

B. Show the allocation of costs below. If necessary, please attach worksheets.

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

SEE ACCOUNTANTS' COMPILATION REPORT

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

1		2		3		4		5		6		7		8		9		10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense								
		YES	NO				Original	Balance											
	A. Directly Facility Related																		
	Long-Term																		
1	LaSalle Bank		X	Mortgage			\$	9,850,000			\$	447,253	1						
2													2						
3													3						
4													4						
5	See Supplemental Schedule												5						
	Working Capital																		
6	LaSalle Bank		X	Line of Credit			2,000,000	120,000	11/30/04	Prime+1	10,708	6							
7												7							
8	See Supplemental Schedule											8							
9	TOTAL Facility Related						\$	2,000,000	\$	9,970,000			\$	457,961	9				
	B. Non-Facility Related*																		
10													10						
11	Interest Income											(396)	11						
12	Allocated From Boulevard HC											5,396	12						
13	See Supplemental Schedule												13						
14	TOTAL Non-Facility Related						\$		\$				\$	5,000	14				
15	TOTALS (line 9+line14)						\$	2,000,000	\$	9,970,000			\$	462,961	15				

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ N/A Line # N/A

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7.
(See instructions.) SEE ACCOUNTANTS' COMPILATION REPORT

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2.
(See instructions.)

B. Real Estate Taxes

NOTES:

1. Please indicate a negative number by use of brackets (). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity. **This denial must be no more than four years old at the time the cost report is filed.**

SEE ACCOUNTANTS' COMPILATION REPORT

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2002 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2002 real estate tax costs, as well as copies of your real estate tax bills for calendar 2002.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2002 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2003 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2002 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Warren Barr Pavilion COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0045146

CONTACT PERSON REGARDING THIS REPORT : Steve Lavenda

TELEPHONE (847) 236-1111 FAX #: (847) 236-1155

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2002 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2002.

(A)	(B)	(C)	(D) <u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	
1. <u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
2. <u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
3. <u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
4. <u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
5. <u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
6. <u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
7. <u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
8. <u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
9. <u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
10. <u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
TOTALS		\$ <u> </u>	\$ <u> </u>

B. Real Estate Tax Cost Allocations

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. Tax Bills

Attach a copy of the 2002 tax bills which were listed in Section A to this statement. Be sure to use the 2002 tax bill which is normally paid during 2003.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2000 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2000 real estate tax costs, as well as copies of your real estate tax bills for calendar 2000.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2000 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2001 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2002 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Warren Barr Pavilion COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0045146

CONTACT PERSON REGARDING THIS REPORT : Steve Lavenda

TELEPHONE (847) 236-1111 FAX #: (847) 236-1155

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2000 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2000.

	(A)	(B)	(C)	(D) <u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
	<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	
1.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
2.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
3.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
4.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
5.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
6.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
7.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
8.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
9.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
10.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
		TOTALS	\$ <u> </u>	\$ <u> </u>

B. Real Estate Tax Cost Allocations

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. Tax Bills

Attach a copy of the 2000 tax bills which were listed in Section A to this statement. Be sure to use the 2000 tax bill which is normally paid during 2001.

A. Square Feet:
 130,152

B. General Construction Type:
 Exterior
 Concrete
 Frame
 Steel
 Number of Stories
 9

C. Does the Operating Entity?
 ☐ (a) Own the Facility
 ☒ (b) Rent from a Related Organization.
 ☐ (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity?
 ☒ (a) Own the Equipment
 ☐ (b) Rent equipment from a Related Organization.
 ☒ (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

None

F. Does this cost report reflect any organization or pre-operating costs which are being amortized?
 ☒ YES
 ☐ NO

If so, please complete the following:

1. Total Amount Incurred:
 359,704

2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization:
 143,518

4. Dates Incurred:

Nature of Costs:
 Closing Costs and Financing Fees
 (Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	<u>Facility</u>		<u>2002</u>	<u>\$ 2,500,000</u>	1
2					2
3	TOTALS			\$ 2,500,000	3

SEE ACCOUNTANTS' COMPILATION REPORT

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					\$	\$		\$	\$	\$	4
5											5
6											6
7											7
8											8
9	Improvement Type**							-		-	9
10								-		-	10
11								-		-	11
12								-		-	12
13								-		-	13
14								-		-	14
15								-		-	15
16								-		-	16
17								-		-	17
18								-		-	18
19								-		-	19
20								-		-	20
21								-		-	21
22								-		-	22
23								-		-	23
24								-		-	24
25								-		-	25
26								-		-	26
27								-		-	27
28								-		-	28
29								-		-	29
30								-		-	30
31								-		-	31
32								-		-	32
33								-		-	33
34								-		-	34
35								-		-	35
36								-		-	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

SEE ACCOUNTANTS' COMPILATION REPORT

	1	2	3	4	5	6	7	8	9	
	Improvement Type**		Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37				\$	\$		\$	\$		37
38										38
39										39
40										40
41										41
42										42
43										43
44										44
45										45
46										46
47										47
48										48
49										49
50										50
51										51
52										52
53										53
54										54
55										55
56										56
57										57
58										58
59										59
60										60
61										61
62										62
63										63
64										64
65										65
66										66
67	Related Building Company (Pages 12-BLDG & 12A-BLDG)			10,110,000	502,292		502,292		547,625	67
68	Related Party Allocations (Pages 12-REP & 12A-REP)			3,733	747		747		1,187	68
69	Financial Statement Depreciation				7,011			(7,011)		69
70	TOTAL (lines 4 thru 69)			\$ 10,113,733	\$ 510,050		\$ 503,039	\$ (7,011)	\$ 548,812	70

**Improvement type must be detailed in order for the cost report to be considered complete.

SEE ACCOUNTANTS' COMPILATION REPORT

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 10,113,733	\$ 510,050		\$ 503,039	\$ (7,011)	\$ 548,812	1
2	Cable Work	2002	3,081		20	26	26	26	2
3	Computer Cabling Install	2003	1,006		20	88	88	88	3
4	Corner Guards	2003	1,824		20	144	144	144	4
5	Refurbish Ice Cream Parlor	2003	311		20	13	13	13	5
6	Domestic Water Pump Ren.	2003	4,996		20	354	354	354	6
7	Domestic Water Pump Ren.	2003	6,600		20	413	413	413	7
8	Domestic Water Pump Ren.	2003	21,074		20	2,020	2,020	2,020	8
9	Plumbing Work	2003	1,938		20	121	121	121	9
10	Wiring For Time Clock Install	2003	1,967		20	82	82	82	10
11	Fire Protection System Install	2003	8,362		20	662	662	662	11
12	Drywall Fire Protection System	2003	120		20	7	7	7	12
13	Sheet Metal Ice Cream Parlor	2003	950		20	40	40	40	13
14	Elevator Recall System	2003	1,267		20	50	50	50	14
15	Elevator Recall System	2003	1,759		20	62	62	62	15
16	Wander Guard Alert System	2003	7,501		20	229	229	229	16
17	Wander Guard Alert System	2003	3,500		20	107	107	107	17
18	Fire Pump Control	2003	5,080		20	233	233	233	18
19	Ice Cream Parlor Ren. Materials	2003	257		20	8	8	8	19
20	Pipe Superfreeze Unit	2003	2,555		20	117	117	117	20
21	Cabling For Computer System	2003	23,430		20	586	586	586	21
22	Furnish Elec. Fire Pump Control	2003	19,327		20	443	443	443	22
23	Demolition Telephone Room	2003	693		20	21	21	21	23
24	Tuckpoint Building	2003	51,103		20	1,597	1,597	1,597	24
25	Concrete Wall Telephone Room	2003	3,850		20	96	96	96	25
26	Upgrade 1st Floor Restrooms	2003	460		20	9	9	9	26
27	Elevator Project Electrical Work	2003	2,203		20	5	5	5	27
28	Elevator Project	2003	6,676		20	14	14	14	28
29	Elevator Project	2003	3,299		20	7	7	7	29
30	6Th Floor Nurse Call	2003	1,272		20	4	4	4	30
31	Wardner Guard 6Th Floor Ren.	2003	1,600		20	4	4	4	31
32	Dementia 6Th Floor Renovation	2003	399		20	1	1	1	32
33	Insulation Mechanical Room	2003	830		20	10	10	10	33
34	TOTAL (lines 1 thru 33)		\$ 10,303,023	\$ 510,050		\$ 510,611	\$ 561	\$ 556,384	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	2	3	4	5	6	7	8	9	10
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		\$ 10,303,023	\$ 510,050		\$ 510,611	\$ 561	\$ 556,384	1
2	Inspection Tuck Pointing	2003	13,363		20	139	139	139	2
3	Demolition	2003	261		20	12	12	12	3
4	Demolition Telephone Room	2003	1,508		20	29	29	29	4
5	Door Locks 6Th Floor Renovation	2003	5,800		20	73	73	73	5
6	Chiller Renovation	2003	17,588		20	220	220	220	6
7	Elevator Project	2003	4,964		20	31	31	31	7
8	Elevator Project	2003	27,266		20	57	57	57	8
9	Out Door Signage	2003	2,181		20	221	221	221	9
10	Pleated Shades	2003	665		20	83	83	83	10
11	Deposit Phone System	2003	36,667		20	3,274	3,274	3,274	11
12	2Nd Install Phone System	2003	51,333		20	3,361	3,361	3,361	12
13	Custom Duette Shades	2003	619		20	33	33	33	13
14	Phone System Balance	2003	53,921		20	1,605	1,605	1,605	14
15	Door Closer	2003	1,225		20	61	61	61	15
16	Door Repair	2003	912		20	42	42	42	16
17	Alarmed Doors	2003	757		20	38	38	38	17
18	Fire Alarm System Repair	2003	562		20	23	23	23	18
19	Hvac	2003	1,650		20	69	69	69	19
20	Hot Water Pump	2003	1,480		20	62	62	62	20
21	Lock Replacement	2003	976		20	41	41	41	21
22	Sprinkler	2003	550		20	21	21	21	22
23	Electric Door Motor	2003	670		20	22	22	22	23
24	Air Pump	2003	554		20	18	18	18	24
25	Compressor	2003	1,809		20	121	121	121	25
26	Faucets	2003	705		20	24	24	24	26
27	Generator Repair	2003	1,475		20	61	61	61	27
28	Lobby Window Replacement	2003	548		20	18	18	18	28
29	Refrigerator Repair	2003	579		20	39	39	39	29
30	Safety Rail Caps	2003	507		20	17	17	17	30
31	Wall Treatments	2003	2,422		20	71	71	71	31
32	Sliding Door	2003	747		20	19	19	19	32
33	Hvac	2003	1,358		20	28	28	28	33
34	TOTAL (lines 1 thru 33)		\$ 10,538,646	\$ 510,050		\$ 520,543	\$ 10,493	\$ 566,317	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		\$ 10,538,646	\$ 510,050		\$ 520,543	\$ 10,493	\$ 566,317	1
2	Overdoor Motor	2003	619		20	13	13	13	2
3	Hvac	2003	1,249		20	26	26	26	3
4	Hvac	2003	389		20	10	10	10	4
5	Hvac	2003	1,584		20	33	33	33	5
6	Phoneline Repairs	2003	748		20	16	16	16	6
7	Replacement Door	2003	732		20	12	12	12	7
8	Floors	2003	2,094		20	26	26	26	8
9	Hvac	2003	635		20	3	3	3	9
10	Cooler Repair	2003	834		20	14	14	14	10
11	Cooler Repair	2003	1,069		20	18	18	18	11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
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24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 10,548,599	\$ 510,050		\$ 520,713	\$ 10,663	\$ 566,488	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	2	3	4	5	6	7	8	9	10
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		\$ 10,548,599	\$ 510,050		\$ 520,713	\$ 10,663	\$ 566,488	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
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21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 10,548,599	\$ 510,050		\$ 520,713	\$ 10,663	\$ 566,488	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)								
B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.								
1	2	3	4	5	6	7	8	9
Improvement Type**	Year	Cost	Current Book	Life	Straight Line	Adjustments	Accumulated	
Constructed			Depreciation	in Years	Depreciation		Depreciation	
1	Totals from Page 12E, Carried Forward	\$ 10,548,599	\$ 510,050		\$ 520,713	\$ 10,663	\$ 566,488	1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30
31								31
32								32
33								33
34	TOTAL (lines 1 thru 33)	\$ 10,548,599	\$ 510,050		\$ 520,713	\$ 10,663	\$ 566,488	34

**Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	2	3	4	5	6	7	8	9	10
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12F, Carried Forward		\$ 10,548,599	\$ 510,050		\$ 520,713	\$ 10,663	\$ 566,488	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 10,548,599	\$ 510,050		\$ 520,713	\$ 10,663	\$ 566,488	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)								
B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.								
1	2	3	4	5	6	7	8	9
Improvement Type**		Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation
1	Totals from Page 12G, Carried Forward		\$ 10,548,599	\$ 510,050		\$ 520,713	\$ 10,663	\$ 566,488
2								
3								
4								
5								
6								
7								
8								
9								
10								
11								
12								
13								
14								
15								
16								
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19								
20								
21								
22								
23								
24								
25								
26								
27								
28								
29								
30								
31								
32								
33								
34	TOTAL (lines 1 thru 33)		\$ 10,548,599	\$ 510,050		\$ 520,713	\$ 10,663	\$ 566,488

**Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	2	3	4	5	6	7	8	9	10
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12H, Carried Forward		\$ 10,548,599	\$ 510,050		\$ 520,713	\$ 10,663	\$ 566,488	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 10,548,599	\$ 510,050		\$ 520,713	\$ 10,663	\$ 566,488	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)								
B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.								
1	2	3	4	5	6	7	8	9
Improvement Type**		Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation
1	Totals from Page 12I, Carried Forward		\$ 10,548,599	\$ 510,050		\$ 520,713	\$ 10,663	\$ 566,488
2								
3								
4								
5								
6								
7								
8								
9								
10								
11								
12								
13								
14								
15								
16								
17								
18								
19								
20								
21								
22								
23								
24								
25								
26								
27								
28								
29								
30								
31								
32								
33								
34	TOTAL (lines 1 thru 33)		\$ 10,548,599	\$ 510,050		\$ 520,713	\$ 10,663	\$ 566,488

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	2	3	4	5	6	7	8	9	10
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12J, Carried Forward		\$ 10,548,599	\$ 510,050		\$ 520,713	\$ 10,663	\$ 566,488	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 10,548,599	\$ 510,050		\$ 520,713	\$ 10,663	\$ 566,488	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued) B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.											
	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	271		2002		\$ 10,110,000	\$ 502,292		\$ 502,292	\$	\$ 547,625	4
5											5
6											6
7											7
8											8
9	Improvement Type**										9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

*Total beds on this schedule must agree with page 2.
 **Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A-BLDG, Line 70 for total
 SEE ACCOUNTANTS' COMPILATION REPORT

XI. OWNERSHIP COSTS (continued)									
B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.									
1	3	4	5	6	7	8	9		
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
37		\$	\$		\$	\$	\$		37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)	\$ 10,110,000	\$ 502,292		\$ 502,292	\$	\$ 547,625		70

**Improvement type must be detailed in order for the cost report to be considered complete.
 SEE ACCOUNTANTS' COMPILATION REPORT

XI. OWNERSHIP COSTS (continued)
 B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					\$	\$		\$	\$	\$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Allocated From Boulevard Healthcare		2002		3,733	747	20	747		1,187	9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

*Total beds on this schedule must agree with page 2.
 See Page 12A-REP, Line 70 for total

**Improvement type must be detailed in order for the cost report to be considered complete.
 SEE ACCOUNTANTS' COMPILATION REPORT

XI. OWNERSHIP COSTS (continued)									
B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.									
1	3	4	5	6	7	8	9		
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
37		\$	\$		\$	\$	\$		37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 3,733	\$ 747		\$ 747	\$	\$ 1,187	70

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 1,128,349	\$ 176,325	\$ 151,075	\$ (25,250)	10	\$ 169,903	71
72	Current Year Purchases	269,303	4,907	24,644	19,737	10	24,644	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 1,397,652	\$ 181,232	\$ 175,719	\$ (5,513)		\$ 194,547	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				\$	\$	\$	\$		\$	76
77										77
78										78
79										79
80	TOTALS			\$	\$	\$	\$		\$	80

E. Summary of Care-Related Assets

	1 Reference	2 Amount	
81	Total Historical Cost (line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 14,446,251	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 691,282	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 696,432	83 **
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 5,150	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 761,035	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		\$	\$	\$	86
87					87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92		\$	92
93			93
94			94
95		\$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

SEE ACCOUNTANTS' COMPILATION REPORT

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: _____

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? _____

If NO, see instructions.

☒ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5	Allocation From Boulevard HC				43,735			5
6								6
7	TOTAL				\$ 43,735			7

8. List separately any amortization of lease expense included on page 4, line 34.

This amount was calculated by dividing the total amount to be amortized
by the length of the lease _____.

9. Option to Buy: ☐ YES ☐ NO Terms: _____ *

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? _____

☐ YES ☒ NO

16. Rental Amount for movable equipment: \$ 32,921 Description: See Attached Schedule

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$	\$	17
18					18
19					19
20					20
21	TOTAL		\$	\$	21

10. Effective dates of current rental agreement:

Beginning _____

Ending _____

11. Rent to be paid in future years under the current rental agreement:

Fiscal Year Ending Annual Rent

12. /2004 \$ _____

13. /2005 \$ _____

14. /2006 \$ _____

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

SEE ACCOUNTANTS' COMPILATION REPORT

Supplemental Schedule of Equipment Rental

12/31/03

Description	Amount
16A G.E. Capital - Fax and Copiers	11,761
16B Distinctive - Copier	6,829
16C Pitney Bowes- Postage Machine	1,008
16D Storage	11,037
16E Allocation From Boulevard Healthcare	2,286
16F	
16G	
16H	
16I	
16J	
16K	
16L	
16M	
16N	
16O	
16P	
16Q	
16R	
16S	
16T	
Total	32,921

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.	2. CLASSROOM PORTION: IN-HOUSE PROGRAM <input type="checkbox"/> IN OTHER FACILITY <input type="checkbox"/> COMMUNITY COLLEGE <input type="checkbox"/> HOURS PER AIDE _____	3. CLINICAL PORTION: IN-HOUSE PROGRAM <input type="checkbox"/> IN OTHER FACILITY <input type="checkbox"/> HOURS PER AIDE _____
---	---	--

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	\$	\$	\$	\$
10	SUM OF line 9, col. 1 and 2 (e)	\$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

\$ _____

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
 (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
 (c) For in-house training programs only. Do not include fringe benefits.
 (d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.

- (e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
 (f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.
SEE ACCOUNTANTS' COMPILATION REPORT

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39 - 03	hrs	\$		\$ 170,772	\$		\$ 170,772	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			38,955			38,955	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			808,119			808,119	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39 - 02	# of prescrpts				594,100		594,100	9
	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							
10			hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): See Supplemental						361,613		361,613	13
14	TOTAL			\$		\$ 1,017,846	\$ 955,713		\$ 1,973,559	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

SEE ACCOUNTANTS' COMPILATION REPORT

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 296,929	\$ 896,793	1
2	Cash-Patient Deposits	31,873	31,873	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	2,933,890	2,933,890	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	8,130	8,130	6
7	Other Prepaid Expenses	88,091	88,091	7
8	Accounts Receivable (owners or related parties)	20,000	1,566,215	8
9	Other(specify): See Attached Schedule			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 3,378,913	\$ 5,524,992	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		2,500,000	13
14	Buildings, at Historical Cost		10,110,000	14
15	Leasehold Improvements, at Historical Cost	260,040	260,040	15
16	Equipment, at Historical Cost	464,832	1,382,842	16
17	Accumulated Depreciation (book methods)	(62,073)	(722,897)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): See Attached Schedule	22,441	232,267	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 685,240	\$ 13,762,252	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 4,064,153	\$ 19,287,244	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 954,785	\$ 6,923,365	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	31,873	31,873	28
29	Short-Term Notes Payable	120,000	120,000	29
30	Accrued Salaries Payable	386,200	386,200	30
31	Accrued Taxes Payable (excluding real estate taxes)	15,913	15,913	31
32	Accrued Real Estate Taxes(Sch.IX-B)	650,000	650,000	32
33	Accrued Interest Payable		38,700	33
34	Deferred Compensation		705	34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Attached Schedule	2,084,078	2,084,078	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 4,242,849	\$ 10,250,834	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		9,850,000	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	See Attached Schedule			43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$ 9,850,000	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 4,242,849	\$ 20,100,834	46
47	TOTAL EQUITY(page 18, line 24)	\$ (178,696)	\$ (813,590)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 4,064,153	\$ 19,287,244	48

SEE ACCOUNTANTS' COMPILATION REPORT

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (39,740)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (39,740)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(138,956)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ (138,956)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ (178,696)	24 *

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

VII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.
Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 15,937,666	1
2	Discounts and Allowances for all Levels	(6,349,317)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 9,588,349	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	5,354,295	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 5,354,295	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	2,466	13
14	Non-Patient Meals	14,686	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	574,332	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	237,621	19
20	Radiology and X-Ray	19,718	20
21	Other Medical Services	138,874	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 987,697	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	396	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 396	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Supplemental Schedule	20,330	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 20,330	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 15,951,067	30

	Expenses	Amount	
	A. Operating Expenses		
31	General Services	3,177,440	31
32	Health Care	5,721,986	32
33	General Administration	3,599,886	33
	B. Capital Expense		
34	Ownership	1,286,095	34
	C. Ancillary Expense		
35	Special Cost Centers	2,156,243	35
36	Provider Participation Fee	148,373	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 16,090,023	40
41	Income before Income Taxes (line 30 minus line 40)**	(138,956)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (138,956)	43

* This must agree with page 4, line 45, column 4.

** Does this agree with taxable income (loss) per Federal Income Tax Return? Not complete If not, please attach a reconciliation.

*** See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation. SEE ACCOUNTANTS' COMPILATION REPORT

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.

Facility Name & ID Number **Warren Barr Pavilion**# **0045146**Report Period Beginning: **01/01/03**Ending: **12/31/03****XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)**

(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing			\$	\$	1
2	Assistant Director of Nursing	1,680	2,232	69,325	31.06	2
3	Registered Nurses	59,628	70,514	1,901,875	26.97	3
4	Licensed Practical Nurses	32,699	36,555	709,853	19.42	4
5	Nurse Aides & Orderlies	147,958	161,198	1,596,171	9.90	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	16,379	18,596	196,215	10.55	8
9	Activity Director	5,873	6,640	117,369	17.68	9
10	Activity Assistants	12,709	15,208	134,329	8.83	10
11	Social Service Workers	12,876	14,624	199,603	13.65	11
12	Dietician					12
13	Food Service Supervisor	6,392	7,129	79,383	11.14	13
14	Head Cook					14
15	Cook Helpers/Assistants	66,680	72,677	661,523	9.10	15
16	Dishwashers					16
17	Maintenance Workers	8,144	9,820	150,044	15.28	17
18	Housekeepers	28,545	30,937	286,965	9.28	18
19	Laundry	6,657	7,459	65,934	8.84	19
20	Administrator	242	263	10,615	40.36	20
21	Assistant Administrator	1,224	1,447	49,108	33.94	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	15,861	18,702	220,162	11.77	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	10,030	11,855	137,541	11.60	31
32	Other Health Care(specify)					32
33	Other(specify) <u>See Supplemental</u>	2,460	2,576	72,856	28.28	33
34	TOTAL (lines 1 - 33)	436,037	488,432	\$ 6,658,871 *	\$ 13.63	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	1,741	\$ 68,045	01-03	35
36	Medical Director	Monthly	68,331	09-03	36
37	Medical Records Consultant	169	5,923	10-03	37
38	Nurse Consultant	5,159	335,306	10-03	38
39	Pharmacist Consultant	Monthly	9,609	10-03	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	447	20,127	11-03	44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	7,516	\$ 507,341		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	445	\$ 20,027	10-03	50
51	Licensed Practical Nurses	3,031	106,095	10-03	51
52	Nurse Aides	463	10,180	10-03	52
53	TOTAL (lines 50 - 52)	3,939	\$ 136,302		53

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number **Warren Barr Pavilion**# **0045146**Report Period Beginning: **01/01/03**Ending: **12/31/03****XIX. SUPPORT SCHEDULES**

A. Administrative Salaries		Ownership	Amount	D. Employee Benefits and Payroll Taxes		Amount	F. Dues, Fees, Subscriptions and Promotions		Amount
Name	Function	%		Description			Description		
Bart T. Becker 11/17/03-12/31/03	Administrator	0%	\$ 10,615	Workers' Compensation Insurance	\$ 193,794		IDPH License Fee	\$	
Tracy Hoover 01/01/03-08/15/03	Asst. Adm.	0%	49,108	Unemployment Compensation Insurance	100,472		Advertising: Employee Recruitment		22,047
				FICA Taxes	493,474		Health Care Worker Background Check		1,912
				Employee Health Insurance	390,538		(Indicate # of checks performed <u>159</u>)		
				Employee Meals			Recruiting Expense		34,792
				Illinois Municipal Retirement Fund (IMRF)*			Advertising		10,002
				Employee Benefits Other	32,584		Dues & Subscriptions		763
				City Employee Tax	4,488		Licenses		7,056
				Employee Disability Insurance	47,700		Yellow Page Advertising		1,884
				Employee Life Insurance	3,743				
				Employee Dental/Vision Insurance	5,032		Less: Public Relations Expense	(
				401K Expense/Union Pension	72,338		Non-allowable advertising		(10,002)
							Yellow page advertising		(1,884)
TOTAL (agree to Schedule V, line 17, col. 1)			\$ 59,723	TOTAL (agree to Schedule V,	\$ 1,344,163		TOTAL (agree to Sch. V,	\$ 66,570	
(List each licensed administrator separately.)				line 22, col.8)			line 20, col. 8)		
B. Administrative - Other				E. Schedule of Non-Cash Compensation Paid to Owners or Employees		G. Schedule of Travel and Seminar**			
Description			Amount	Description	Line #	Amount	Description		Amount
Management Fee-Boulevard			\$ 957,410				Out-of-State Travel	\$	
							In-State Travel		
TOTAL (agree to Schedule V, line 17, col. 3)			\$ 957,410						
(Attach a copy of any management service agreement)									
C. Professional Services									
Vendor/Payee	Type		Amount						
Sachnoff & Weaver, LTD	Legal		\$ 12,325						
Health Data Systems, Inc.	Data Processing		10,431						
Medi.Com	Data Processing		1,766						
Linda Lipinski	Human Resources		1,950						
Trenaman Consulting Group	Accounts Receivable Cnslt.		7,000						
Tobin, Merritt & Associates, Inc	Administrative		22,523						
Bianculi & Implic	Legal		201						
ADP	Data Processing		31,579						
CDW	Data Processing		4,641						
TOTAL (agree to Schedule V, line 19, column 3)				TOTAL		\$			
(If total legal fees exceed \$2500 attach copy of invoices.)			\$ 92,416						

* Attach copy of IMRF notifications
SEE ACCOUNTANTS' COMPILATION REPORT

**See instructions.

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1 Improvement Type	2 Month & Year Improvement Was Made	3 Total Cost	4 Useful Life	5	6	7	8	9	10	11	12	13
					Amount of Expense Amortized Per Year								
					FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008
1	N/A		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number **Warren Barr Pavilion**

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN, LPN, NA) represented by a union? Yes
- (2) Are there any dues to nursing home associations included on the cost report? No
If YES, give association name and amount.
- (3) Did the nursing home make political contributions or payments to a political action organization? Yes If YES, have these costs been properly adjusted out of the cost report? Yes
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity?
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? 10 Years
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 17,500 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease. N/A
- (9) Are you presently operating under a sublease agreement? YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. \$ 148,373
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.

SEE ACCOUNTANTS' COMPILATION REPORT

- (13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ Has any meal income been offset against related costs? N/A Indicate the amount. \$ N/A
- (16) Travel and Transportation
- a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
- b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A
- c. What percent of all travel expense relates to transportation of nurses and patients? N/A
- d. Have vehicle usage logs been maintained? N/A
- e. Are all vehicles stored at the nursing home during the night and all other times when not in use? N/A
- f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
- g. Does the facility transport residents to and from day training? No**
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? No
Firm Name: N/A The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? N/A If no, please explain. N/A
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report? Yes
Attach invoices and a summary of services for all architect and appraisal fees.